

14297

## CERTIFICATE OF DEATH

14268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>413 Claiborne Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Askins</u> Last <u>Askins</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 3, 1896</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Tailor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Raymond Askins</u> Address <u>413 Claiborne St. Salisbury Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Artemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> (c) <u>Rectal bleeding - Polyps</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>  </u> , to <u>12/9/59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>12/9/59</u> , 19 <u>  </u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>AC Smith</u>		M.D. <u>Salisbury, Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>12/10/59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/ 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1001

## CERTIFICATE OF DEATH

Reg. Dist. No.

14269

14349

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1</b>		d. STREET ADDRESS <b>R.D.# 1</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>ESMA</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>1st</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Mardela (Wico. Co) Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Jefferson Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Matilda E. Goslee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Informant Mrs. Rachel A. Bailey (Wife) R.D.# 1 Mardela, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>104 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1945</b> to <b>Dec 1, 1959</b> , that I last saw the deceased alive on <b>Dec 1, 1959</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.S. Kuhlman</b>		ADDRESS (Street, city or town, state) <b>Dec. 2, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H.S. Kuhlman</b>		DATE SIGNED <b>Dec. 2, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery (New Part) Mardela, Maryland</b>
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

1934

CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
14298  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 14270

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>5Years 9Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Lena</b> Last <b>Bantum</b>		4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1883</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Trusty</b>		14. MOTHER'S MAIDEN NAME <b>Yorker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular</b> DUE TO <b>Ear Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis General, advanced</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Gangrene of Right Foot due to Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/17/</b> , 19 <b>54</b> , to <b>12/24/</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/24/59</b> , 19 <b>59</b> , and that death occurred at <b>9:45PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>		DATE SIGNED <b>12/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>James Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near - Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Wally</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1970

CERTIFICATE OF DEATH

1970

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Place of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14299

CERTIFICATE OF DEATH

Reg. Dist. No.

14271

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>B ox 232, Rt. 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>L.</b> Last <b>Bartlett</b>				4. DATE OF DEATH Month <b>December</b> Day <b>9,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1893</b>	
9. AGE (In years lost birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>1st World War-</b>				16. SOCIAL SECURITY NO. <b>4,029,805</b>		17. INFORMANT <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Infarcts in brain, heart and left kidney; Diabetes mellitus.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>December 8, 19 59</b> , to <b>December 9, 19 59</b> , that I last saw the deceased alive on <b>December 9, 19 59</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>12/10/59</b>							
ACTUAL SIGNATURE <b>G. Kosmahly</b>				M.D. <b>Deer's Head State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>De 12, 1959</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





14300

## CERTIFICATE OF DEATH

Reg. Dist. No.

14272

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBUARY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>23X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>H.</u> Last <u>BRADFORD</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1 - 1893</u>
9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Newark md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Bradford</u>		14. MOTHER'S MAIDEN NAME <u>Alice B. Halston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0304</u>	
17. INFORMANT <u>Mr. J. Russell Bradford</u>		Address <u>Newark md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>561.0</u> DUE TO <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Maximal Right Heart Failure and</u> (c) <u>Various Veins</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12.18</u> , 19 <u>59</u> , to <u>12.28</u> , 19 <u>59</u> , that I lost the deceased alive on <u>12.28</u> , 19 <u>59</u> , and that death occurred at <u>8:58</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Brickle</u>		ADDRESS (Street, city or town, state) <u>Medical Center 12031-9</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Brickle</u>		M.D. <u>Suburban Md</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Dec 31/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bowen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newark md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May B. Dennis</u>		ADDRESS <u>Snowhill, Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

14273

14301

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>83x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sallie Powell</u> First Middle Last				4. DATE OF DEATH <u>December 27</u> 19 <u>59</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1893</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Ocean City Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charlie W. Bradford</u>				14. MOTHER'S MAIDEN NAME <u>Lida Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>MI Floyd Bradford</u> INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure with Uremia</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized; Diffuse vasculitis and Gangrene Rt Leg.</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>59</u> , to <u>Dec. 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>59</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u> DATE SIGNED <u>12/27/59</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mechanic</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague DE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salzer</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

082

2

VS A15 (4)  
15M 9/58

1

1

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

## Reg. Dist. No.

14274

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Francis</b> Last <b>Brimer</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/31/1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Sammie Brimer</b>	
14. MOTHER'S MAIDEN NAME <b>Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>	
16. SOCIAL SECURITY NO. <b>Unk.</b>		INFORMANT <b>Deer's Head State Hospital</b> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Arteriosclerosis - general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Status post fracture of right 8th, 9th and 10th ribs with pneumothorax</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Dec. 1</b> , 19 <b>59</b> , to <b>Dec. 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 9</b> , 19 <b>59</b> , and that death occurred at <b>1:10 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D. <b>Deer's Head State Hospital</b> <b>12/9/59</b> PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b> <b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>FOREMAN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.

VS A15 (4)  
15M 9/5B

CERTIFICATE OF DEATH

1903

60

12

*[Faint, mostly illegible text on a form, likely containing fields for name, age, sex, date of death, and cause of death.]*



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>SOMERSET</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Estena</u> Middle <u>Burnett</u> Last <u>Burnett</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Fm</u>		6. COLOR OR RACE <u>A.A.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>		IF UNDER 24 HRS. Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seaford</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Cristfield Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Mary White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NOT KNOWN</u>			
17. INFORMANT <u>George Burnett</u>				Address <u>Wenona, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Cerebrovascular Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>9 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 19</u> , 19 <u>59</u> , to <u>Dec 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>157</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Helf</u> M.D.				ADDRESS (Street, city or town, state) <u>Prine Bluff Road</u> DATE SIGNED <u>12/27/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Deale Island, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u> ADDRESS <u>Salisbury, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 31 '59</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14897

CERTIFICATE OF DEATH

1913

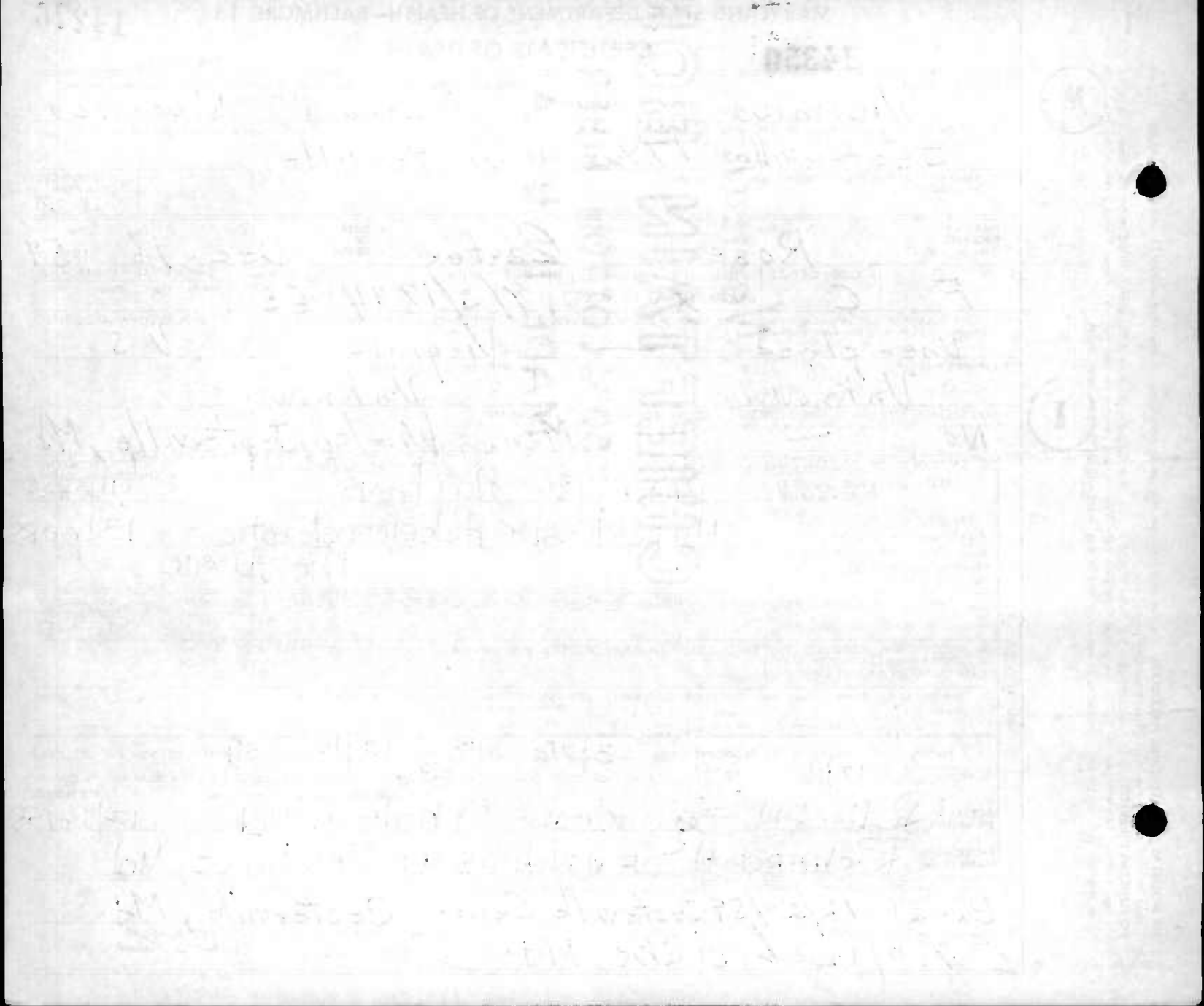
(10)

*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]*

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>	
c. LENGTH OF STAY IN 1b <u>17yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>	
d. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>Carter</u> Middle <u>Carter</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Marian Woodley, Jesterville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X PARALYSIS AGITANS</u> DUE TO (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u> <u>13 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>48</u> , to <u>12/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u>		ADDRESS (Street, city or town, state) <u>Nanticoke Md</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS M.D. NANTICOKE MD</u>		DATE SIGNED <u>12/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Jesterville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick, Bideve, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



M

X

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MEDICAL CERTIFICATION

DP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14277

14351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 Sharps Point</b>				d. STREET ADDRESS <b>R.D.# 1 Sharps Point</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ESTELLE</b> Last <b>CATHELL</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>14th</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1867</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Fruitland, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William W. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Theodosia Disharoon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
17. Address <b>Mrs. W. Boyd Brittingham (Daughter) R.D.# 1 Sharps Point Salisbury, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic gall bladder disease, congestive heart failure</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>Dec 14th</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 14th</b> , 19 <b>59</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dec. 16 / 1959</b> ACTUAL SIGNATURE <b>Dr. E.C. Sutter</b> M.D. <b>Dames Quarter, Maryland</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>							

CERTIFICATE OF DEATH

12321

20

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_

13. Name of registrar: \_\_\_\_\_

14. Name of hospital: \_\_\_\_\_

15. Name of attending physician: \_\_\_\_\_

16. Name of medical examiner: \_\_\_\_\_

17. Name of coroner: \_\_\_\_\_

18. Name of funeral home: \_\_\_\_\_

19. Name of cemetery: \_\_\_\_\_

20. Name of burial place: \_\_\_\_\_



## CERTIFICATE OF DEATH

Reg. Dist. No.

14278

14304

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kisiah (Kitty) B. Chatham</u>		4. DATE OF DEATH Month Day Year <u>December 14 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 7, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>4 7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hollands Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Manzora Walters</u>		14. MOTHER'S MAIDEN NAME <u>ANNE / XXXX / Annie Windsor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mr. Norman G. Chatham Sr. (Husband) R.D.# 2 Siloam Eden, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 hours</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 Dec, 1959, to 14 Dec, 1959</u> , that I last saw the deceased alive on <u>14 Dec, 1959</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Adkins</u> M.D. <u>FRUITLAND, Maryland</u>		DATE SIGNED <u>12/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Robert T Adkins</u>		<u>Fruitland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Siloam Church Cemetery - R.D.# Eden (Siloam) Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hunt</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



1910

1910

1910

1910

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1910

14305

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic</u> d. STREET ADDRESS <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>LEE</u> Last <u>CLUFF</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack County, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Watson</u>		14. MOTHER'S MAIDEN NAME <u>Janie Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Robert Cluff</u>		Address <u>Atlantic, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (Thrombosis)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <u>Cerebral Arteriosclerosis and Hypertension</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus with Diabetic Acidosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 12, 1959</u> to <u>Dec. 14, 1959</u> that I last saw the deceased alive on <u>Dec. 13, 1959</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road, Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>		DATE SIGNED <u>12/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem</u>		22d. LOCATION (City, town, or county) (State) <u>Mr. Temperanceville, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas, Accomack, VA</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

182

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1900



*[Faint, mostly illegible text from the reverse side of the document, including names and dates.]*

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

13p

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										14280			
14352										CERTIFICATE OF DEATH			
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pittsville</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pittsville (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# Powellville</b>					d. STREET ADDRESS <b>R.D.# Powellville</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EMILY</b> Last <b>COLLINS</b>					4. DATE OF DEATH Month <b>Dec.</b> Day <b>23rd</b> Year <b>59</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16, 1914</b>		9. AGE (In years lost birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>Worcester Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Levin H. Collins</b>					14. MOTHER'S MAIDEN NAME <b>Sadie W. Hales</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>INFORMANT</b>					Address <b>Mrs. Edna E. Kelly (Sister) R.D.# Powellville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Congestive Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO <b>5 years</b> (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>May 1957</b> to <b>December 1959</b> , that I last saw the deceased alive on <b>Dec. 23</b> , 19 <b>59</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dec. 24 1959</b> DATE SIGNED													
ACTUAL SIGNATURE <b>Robert A. Grubb</b>					M.D. <b>Dec. 24 1959</b>								
PHYSICIAN'S NAME (Type) <b>Dr. Robert A. Grubb</b>					Bay St. Berlin, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>Dec. 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Collins Family Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Powellville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>					ADDRESS <b>SALISBURY MARYLAND</b>			24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

11

1955

OFFICE OF THE ATTORNEY GENERAL

1955

STATE OF NEW YORK  
IN SENATE  
January 11, 1955  
REPORT  
OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF SOCIAL SERVICES  
ON THE  
ADMINISTRATIVE AND FINANCIAL  
OPERATIONS OF THE  
DEPARTMENT OF SOCIAL SERVICES  
FOR THE YEAR 1954  
ALBANY: J.B. LIPPINCOTT COMPANY, 1955



14306

CERTIFICATE OF DEATH

14281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Costen</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13 - 1917</u> 43/8/21	
9. AGE (In years last birthday) <u>41</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>21</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
13. FATHER'S NAME <u>J. Thomas Evans</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Mr. Edward S. Costen</u> Address <u>Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 190.7 DUE TO <u>Malignant Melanoma of toes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yrs</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11:26</u> , 19 <u>59</u> , to <u>12:3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12:2</u> , 19 <u>59</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Briele</u>				ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>12-3-59</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>				M.D. <u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 4/59</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Bates Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Gummis</u> ADDRESS <u>Snow Hill, Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MICHIGAN - DEPARTMENT OF HEALTH

1921



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14302

## CERTIFICATE OF DEATH

Reg. Dist. No.

14282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>DAISEY</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 4, 1959</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MANFORD DAISEY</u>		14. MOTHER'S MAIDEN NAME <u>AGNES LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>MANFORD DAISEY</u>		18. ADDRESS <u>PARSONSBURG MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (990 gms)</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/4</u> , 19 <u>59</u> , to <u>12/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>59</u> , and that death occurred at <u>2:58</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>12/6/59</u> ACTUAL SIGNATURE <u>Alfred C. Koll</u> M.D. PHYSICIAN'S NAME (Type) <u>Salisbury MD.</u>			
22a. BURIAL, CREMATION, EMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MERCHANICS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MILLSBORO DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

2082335XVO

CERTIFICATE OF DEATH

1908

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1908-1909

14308

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14283

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Wicomico</u> Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 Poplar Hill Ave.</u>				d. STREET ADDRESS <u>315 Poplar Hill Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Weldon</u> Middle <u>L</u> Last <u>Dashiell</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 10 1914</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orderly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Dashiell</u>				14. MOTHER'S MAIDEN NAME <u>Georgia M. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-5320</u>		17. INFORMANT Address <u>Mrs. Nellie Dashiell, 657 W. Main St., Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>880.0</u> DUE TO <u>Acute alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Over indulgence alcohol</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>12 18</u> 19 <u>59</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>				24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton S. Hana</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





14309

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u> d. STREET ADDRESS <u>1240 Cold Spring Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>E.</u> Last <u>DeOtley</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co., Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Honora Logsdon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Joseph Truitt</u>		Address <u>85 Weber Ave. Middle River</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis generalized</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 17</u> , 19 <u>59</u> , to <u>Dec. 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DECEMBER 8</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Cook, M.D.</u>		ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



CONFIDENTIAL

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-157341)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14310

CERTIFICATE OF DEATH

Reg. Dist. No.

14285

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM THOMAS DIX</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 20 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 15, 1900</u>
9. AGE (In years last birthday) yrs. <u>59</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM T. DIX</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BUNDICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>220-32-9901</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction Right Atrium</u> DUE TO (c) <u>Arteriosclerotic Coronary artery disease + Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5-6 days?</u> <u>3-4 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis abdominal aorta at coeliac place -</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/19/59</u> , 19 <u>59</u> , to <u>12/20/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20/59</u> , 19 <u>59</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		ADDRESS (Street, city or town, state) <u>707 Camden Avenue Salisbury Md.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>		DATE SIGNED <u>12/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MODEST TOWN BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>MODEST TOWN VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
ADDRESS <u>POCOMOKE CITY, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Henth</u>	

1921

CERTIFICATE OF DEATH

1921

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14286

14311

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Life Time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> <b>19X-2</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>													
3. NAME OF DECEASED (Type or print) First <b>Weldon</b> Middle <b>Doane</b> Last				4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>59</b>									
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/I/1942</b>		9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Boy</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>			
13. FATHER'S NAME <b>Herschel Doane</b>						14. MOTHER'S MAIDEN NAME <b>Hattie Trapp</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hattie Doane Princess Anne, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Second and third degree burns 90% body surface.</b> DUE TO <b>916.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned when oil stove exploded in home on 12-20-59</b>									
20c. TIME OF INJURY Hour <b>P.M.</b> o. m. <b>12-20-59</b>		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home.</b>		20f. (City or town) <b>Princess Ann Somerset Md.</b>		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) <b>Princess Anne, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr Princess Anne, Md</b>						ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF HEALTH OFFICER		23. SIGNATURE OF VITALS		24. SIGNATURE OF RECORDS	
25. SIGNATURE OF ARCHIVES		26. SIGNATURE OF INDEX		27. SIGNATURE OF FILE	
28. SIGNATURE OF CLERK		29. SIGNATURE OF ASSISTANT		30. SIGNATURE OF SUPERVISOR	
31. SIGNATURE OF CHIEF		32. SIGNATURE OF DEPUTY		33. SIGNATURE OF ASSISTANT DEPUTY	
34. SIGNATURE OF CLERK		35. SIGNATURE OF ASSISTANT		36. SIGNATURE OF SUPERVISOR	
37. SIGNATURE OF CHIEF		38. SIGNATURE OF DEPUTY		39. SIGNATURE OF ASSISTANT DEPUTY	
40. SIGNATURE OF CLERK		41. SIGNATURE OF ASSISTANT		42. SIGNATURE OF SUPERVISOR	
43. SIGNATURE OF CHIEF		44. SIGNATURE OF DEPUTY		45. SIGNATURE OF ASSISTANT DEPUTY	
46. SIGNATURE OF CLERK		47. SIGNATURE OF ASSISTANT		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF CHIEF		50. SIGNATURE OF DEPUTY		51. SIGNATURE OF ASSISTANT DEPUTY	
52. SIGNATURE OF CLERK		53. SIGNATURE OF ASSISTANT		54. SIGNATURE OF SUPERVISOR	
55. SIGNATURE OF CHIEF		56. SIGNATURE OF DEPUTY		57. SIGNATURE OF ASSISTANT DEPUTY	
58. SIGNATURE OF CLERK		59. SIGNATURE OF ASSISTANT		60. SIGNATURE OF SUPERVISOR	
61. SIGNATURE OF CHIEF		62. SIGNATURE OF DEPUTY		63. SIGNATURE OF ASSISTANT DEPUTY	
64. SIGNATURE OF CLERK		65. SIGNATURE OF ASSISTANT		66. SIGNATURE OF SUPERVISOR	
67. SIGNATURE OF CHIEF		68. SIGNATURE OF DEPUTY		69. SIGNATURE OF ASSISTANT DEPUTY	
70. SIGNATURE OF CLERK		71. SIGNATURE OF ASSISTANT		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF CHIEF		74. SIGNATURE OF DEPUTY		75. SIGNATURE OF ASSISTANT DEPUTY	
76. SIGNATURE OF CLERK		77. SIGNATURE OF ASSISTANT		78. SIGNATURE OF SUPERVISOR	
79. SIGNATURE OF CHIEF		80. SIGNATURE OF DEPUTY		81. SIGNATURE OF ASSISTANT DEPUTY	
82. SIGNATURE OF CLERK		83. SIGNATURE OF ASSISTANT		84. SIGNATURE OF SUPERVISOR	
85. SIGNATURE OF CHIEF		86. SIGNATURE OF DEPUTY		87. SIGNATURE OF ASSISTANT DEPUTY	
88. SIGNATURE OF CLERK		89. SIGNATURE OF ASSISTANT		90. SIGNATURE OF SUPERVISOR	
91. SIGNATURE OF CHIEF		92. SIGNATURE OF DEPUTY		93. SIGNATURE OF ASSISTANT DEPUTY	
94. SIGNATURE OF CLERK		95. SIGNATURE OF ASSISTANT		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF CHIEF		98. SIGNATURE OF DEPUTY		99. SIGNATURE OF ASSISTANT DEPUTY	
100. SIGNATURE OF CLERK		101. SIGNATURE OF ASSISTANT		102. SIGNATURE OF SUPERVISOR	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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14287

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# 1</b>				d. STREET ADDRESS <b>R.D.# 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>RAYMOND</b> Last <b>DRYDEN</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>22nd</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1886</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Bryden</b>			14. MOTHER'S MAIDEN NAME <b>Unk</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-16-5539</b>		17. INFORMANT <b>Mr. Elton Lee Dryden (Son)</b> Address <b>619 E. 9th St. Chester, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> <b>Sudden</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Dec. <b>23</b> 1959	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Eden, Maryland</b>	
23. BURIAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



# MARIAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## 14358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		COUNTY OF BALTIMORE DISTRICT OF BALTIMORE	
NAME OF DECEASED JAMES EARL RAY		SEX Male	
AGE 35		DATE OF BIRTH JAN 5 1928	
PLACE OF BIRTH MOBILE, ALABAMA		OCCUPATION None	
MARITAL STATUS Single		CAUSE OF DEATH Gunshot wound	
MANNER OF DEATH Homicide		PLACE OF DEATH Room 306, Lorraine Hotel, Baltimore, Md.	
TIME OF DEATH 10:15 PM		DATE OF DEATH APR 4 1968	
SIGNATURE OF EXAMINER [Signature]		SIGNATURE OF WITNESS [Signature]	
EXAMINER'S CERTIFICATE I have examined the body of the deceased and find that the above information is true and correct.		WITNESS I have witnessed the examination and find that the above information is true and correct.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14312

CERTIFICATE OF DEATH

Reg. Dist. No.

14288

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>46X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MIRIAM</u> First <u>L.</u> Middle <u>DUKES</u> Last				4. DATE OF DEATH <u>DECEMBER 29 1959</u> Month <u>DECEMBER</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 17 1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Archib M. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Cora A. Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>222-07-3234</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - Brain</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of Lung - Bronchogenic?</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 December 1959</u> to <u>29 December 1959</u> , that I last saw the deceased alive on <u>29 Dec. 59</u> , 19 <u>59</u> , and that death occurred at <u>7:12 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>				ADDRESS (Street, city or town, state) <u>707 Camden Avenue</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rafana</u>		22d. LOCATION (City, town, or county) (State) <u>Rafana Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>				24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. House</u>	

1913

DECEASED

DATE OF DEATH

PLACE OF DEATH

MASSACHUSETTS

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

EDUCATION

RELIGION

Signature of Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14313

CERTIFICATE OF DEATH

Reg. Dist. No. 14289

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>Life Time</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>ELzey</u> Last <u>ELzey</u>			4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Privet Family</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S .A.</u>
13. FATHER'S NAME <u>Samuel Dennis</u>			14. MOTHER'S MAIDEN NAME <u>Martha Hayman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	INFORMANT Address <u>Viola Brown. Philadelphia, Pa</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumococcal Meningitis</u> <u>340.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12-24</u> , 19 <u>59</u> , to <u>12-26</u> , 19 <u>59</u> , that I lost sow the deceased olive on <u>12-26</u> , 19 <u>59</u> , and that death occurred at <u>4 P.</u> M, from the causes ond on the dote stated above.					
ACTUAL SIGNATURE <u>Willbur R. Gelles</u> M.D.			ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 12-26-59</u>		
PHYSICIAN'S NAME (Type) <u>Willbur R. Gelles</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>		ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>

CERTIFICATE OF DEATH

1981

1981

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Race: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Address of informant: \_\_\_\_\_

15. City: \_\_\_\_\_

16. State: \_\_\_\_\_

17. Zip: \_\_\_\_\_

18. Date of filing: \_\_\_\_\_

19. File number: \_\_\_\_\_

20. Registrar's office: \_\_\_\_\_

21. Registrar's name: \_\_\_\_\_

22. Registrar's title: \_\_\_\_\_

23. Registrar's address: \_\_\_\_\_

24. Registrar's phone: \_\_\_\_\_

25. Registrar's fax: \_\_\_\_\_

26. Registrar's email: \_\_\_\_\_

27. Registrar's website: \_\_\_\_\_

28. Registrar's social media: \_\_\_\_\_

29. Registrar's contact information: \_\_\_\_\_

30. Registrar's office hours: \_\_\_\_\_

31. Registrar's office location: \_\_\_\_\_

32. Registrar's office building: \_\_\_\_\_

33. Registrar's office floor: \_\_\_\_\_

34. Registrar's office room: \_\_\_\_\_

35. Registrar's office suite: \_\_\_\_\_

36. Registrar's office wing: \_\_\_\_\_

37. Registrar's office level: \_\_\_\_\_

38. Registrar's office area: \_\_\_\_\_

39. Registrar's office zone: \_\_\_\_\_

40. Registrar's office sector: \_\_\_\_\_

41. Registrar's office division: \_\_\_\_\_

42. Registrar's office department: \_\_\_\_\_

43. Registrar's office branch: \_\_\_\_\_

44. Registrar's office unit: \_\_\_\_\_

45. Registrar's office group: \_\_\_\_\_

46. Registrar's office team: \_\_\_\_\_

47. Registrar's office staff: \_\_\_\_\_

48. Registrar's office personnel: \_\_\_\_\_

49. Registrar's office employees: \_\_\_\_\_

50. Registrar's office workers: \_\_\_\_\_

51. Registrar's office members: \_\_\_\_\_

52. Registrar's office associates: \_\_\_\_\_

53. Registrar's office partners: \_\_\_\_\_

54. Registrar's office affiliates: \_\_\_\_\_

55. Registrar's office subsidiaries: \_\_\_\_\_

56. Registrar's office divisions: \_\_\_\_\_

57. Registrar's office departments: \_\_\_\_\_

58. Registrar's office branches: \_\_\_\_\_

59. Registrar's office units: \_\_\_\_\_

60. Registrar's office groups: \_\_\_\_\_

61. Registrar's office teams: \_\_\_\_\_

62. Registrar's office staff: \_\_\_\_\_

63. Registrar's office personnel: \_\_\_\_\_

64. Registrar's office employees: \_\_\_\_\_

65. Registrar's office workers: \_\_\_\_\_

66. Registrar's office members: \_\_\_\_\_

67. Registrar's office associates: \_\_\_\_\_

68. Registrar's office partners: \_\_\_\_\_

69. Registrar's office affiliates: \_\_\_\_\_

70. Registrar's office subsidiaries: \_\_\_\_\_

## CERTIFICATE OF DEATH

Reg. Dist. No.

14290

14314

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 Isabella St</b>		d. STREET ADDRESS <b>1 110 E. Isabella St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EVELYN</b> Middle <b>GEORGIA</b> Last <b>EVANS</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>14th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Venetian Blind Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accomac County Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Marsh</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. Mrs. Oren Carroll (Daughter) Drive Aberdeen, Maryland		Address <b>Grace Ford</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1 Carcinomatosis [Cerebral, hepatic, &amp; visceral]</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>visceral</b> DUE TO (c) <b>Adenocarcinoma of Colon</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>6 mos +</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/21</b> , 19 <b>59</b> , to <b>12/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/14</b> , 19 <b>59</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pine Bluff Road Salisbury, Md.</b> DATE SIGNED <b>Dec. 17, 1959</b>			
ACTUAL SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

[illegible text]



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14315

## CERTIFICATE OF DEATH

Reg. Dist. No.

14291

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Delaware</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Selbyville 46 X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL.</i>		d. STREET ADDRESS <i>--</i>	
3. NAME OF DECEASED (Type or print) First <i>Morris</i> Middle <i>M.</i> Last <i>EVANS</i>		4. DATE OF DEATH Month <i>December</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 10, 1959</i>
9. AGE (In years lost birthday) yrs. <i>0</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>13</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>ROYCE WAYNE EVANS</i>		14. MOTHER'S MAIDEN NAME <i>BARBARA JEAN MITCHELL.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Royce Evans Selbyville Del</i>		Address:	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral edema and intracranial hemorrhage</i> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intrauterine Anoxia</i> DUE TO (c) <i>Prematurity + Placenta separation</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/10</i> , 19 <i>59</i> , to <i>12/10</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12/10</i> , 19 <i>59</i> , and that death occurred at <i>7 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Morgan M.D.</i>		ADDRESS (Street, city or town, state) <i>Medical Center Selbyville, Md</i>	
PHYSICIAN'S NAME (Type) <i>William C. Morgan</i>		DATE SIGNED <i>12/10/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-12-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Alver Cemetery Near Prince Georges</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Teris R. Wilkins Prince Georges Md</i>		ADDRESS <i>2082274 XVI</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
DATE <i>DEC 17 '59</i>			



CERTIFICATE OF DEATH

16313

Born 1535 AM

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14316

CERTIFICATE OF DEATH

Reg. Dist. No.

14292

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>5 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 Tanez Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wesley</u> Last <u>GAVIN, Jr</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-13, 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WAYNE Pump.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM W. GAVIN</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>Mrs. Wm Gavin - Same</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>151X</u> IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>11:27</u> , 19 <u>59</u> , to <u>12:41</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12:3</u> , 19 <u>59</u> , and that death occurred at <u>12:41</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Briele</u>		M.D. <u>  </u>		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u>			
DATE SIGNED <u>12-4-59</u>							
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-5-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co Salisbury,</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>		DATE <u>DEC 9 '59</u>	

CERTIFICATE OF DEATH

1911

1911

1911

1911

1911

1911

1911

14317

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b> <b>75 x 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Sanitarium</b>		d. STREET ADDRESS <b>1922 Laval St</b>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>ELLEN</b> Last <b>GRAVES</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>14th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Merrill Leonard Morris</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Hester Holman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Mr. John P. Graves (Son)</b>		17. ADDRESS <b>Philadelphia, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Generalized Arteriosclerosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>59</b> , to <b>12/14</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>12/14</b> , 19 <b>59</b> , and that death occurred at <b>12:00</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md</b> DATE SIGNED <b>Dec. 16, 1959</b>			
ACTUAL SIGNATURE <b>F. R. Gramse</b>		M.D. <b>Salisbury, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		<b>S. Division St. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 16, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 11 1941

## CERTIFICATE OF DEATH

Reg. Dist. No.

14294

14318

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>26 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne 19x-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>Hampden Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Mason</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 29, 1884</b>		9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseman &amp; Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Fairmount, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Hall</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Hospital Records -- Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X Brochi Broncha-Pneumonia Bilateral</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arteriosclerosis Right Hemiparesis Neuro-Lues A.C.V.D.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>12/1/</b> 19 <b>59</b> , to <b>12/26/</b> 19 <b>59</b> that I last saw the deceased alive on <b>12/26/</b> 19 <b>59</b> , and that death occurred at <b>11:35 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>12/26/59</b>							
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D. <b>Salisbury, Maryland</b> <b>12/26/59</b>					
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willaim H. James Jr. Princess Anne, Md</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

Decedent

Residence

Age

Sex

Married

Single

Widow

Occupation

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature

Physician

Signature

Physician

Signature

Physician

Signature

Physician

Signature

Physician

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Physician

Signature



## CERTIFICATE OF DEATH

Reg. Dist. No. 14295

14319

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTOPHER ALAN Hargreaves</u>		4. DATE OF DEATH Month Day Year <u>December 23-1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>BABY</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1959</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury (Hosp) Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard C. Hargreaves</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mr. Bernard C. Hargreaves (Father) 405 Priscilla St Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Prolapse of Umbilical Cord</u> DUE TO (c) <u>approx 6 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>12/20/59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/20, 1959</u> to <u>12/23, 1959</u> , that I last saw the deceased alive on <u>12/23, 1959</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center 12/23/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082343XV6

1931

1931

1931



14320

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1409 S. Div. St.</u>	
3. NAME OF DECEASED (Type or print) <u>Maggie Foskey Hastings</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN Foskey</u>		14. MOTHER'S MAIDEN NAME <u>JANE WORKMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service: <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Wm McClelland</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950, Jan 12/27</u> , 19 <u>27</u> , that I last saw the deceased alive on <u>12/27/59</u> , 19 <u>59</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u>		<u>S. Div. St, Salisbury, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-29-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co, Salisbury, Md.</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14354

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Milbourn W Heath</u>		4. DATE OF DEATH <u>Dec. 9</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Henry Heath</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Maley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350x Paralysis Agitans.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u><del>Arteriosclerotic Heart Disease</del></u> DUE TO (c) <u>P.H.S.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 Aug</u> , 19 <u>47</u> to <u>9 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Dec</u> , 19 <u>59</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS</u>		DATE SIGNED <u>12/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wic. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messick, Salisbury, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 16 '59</u>		<u>Arthur S. Kraus</u>	

Charles M. Bowers, M.D.  
Burial 12/12/29 Mc Memorial Park Salisbury, Md

No  $\frac{1}{2}$  — Edna Willard Bowers, Md

William Henry Heath  
Merchant (Gen Store) Maryland

Male White x 2/21/883 77

Milbourn W. Heath Dec 7, 29

Teste-wille Littleme Teste-wille

W. C. M. 1883



## CERTIFICATE OF DEATH

Reg. Dist. No.

14321

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>19X-2</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Somerset</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles P. Holland</i>		4. DATE OF DEATH Month Day Year <i>DECEMBER 6 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 9 1873</i>	9. AGE (In years last birthday) <i>85</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Waterman</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Wm. Thomas Halland</i>		14. MOTHER'S MAIDEN NAME <i>May W. Crosswell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>7</i>	
17. INFORMANT <i>Mr. Clarence Halland</i>		Address <i>Farmington</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>4 yrs</i> <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>June 6, 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 6, 1959</i> , to <i>Dec 6, 1959</i> , that I last saw the deceased alive on <i>Dec 6, 1959</i> , and that death occurred at <i>4:40 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Princess Anne Md</i>		DATE SIGNED <i>12/8/59</i>		ACTUAL SIGNATURE <i>R. Frank Giganti</i>	
PHYSICIAN'S NAME (Type) <i>B. FRANK GIGANTI</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>12-8-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Farmington Cemetery</i>	
22d. LOCATION (City, town, or county) (State) <i>Farmington Md</i>		24a. REC'D BY REGISTRAR <i>Charles S. Thomas</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>		24c. DATE <i>DEC 14 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1831

TESTIMONY OF DEATH

1831



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14299

14322

1. PLACE OF DEATH a. COUNTY <u>WILCOMING</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RODNEY MELOY HUDSON</u>		4. DATE OF DEATH Month Day Year <u>December 11 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 7, 1887</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-POULTRY</u>	11. BIRTHPLACE (State or foreign country) <u>MILLSBORO, DEL.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE F. HUDSON</u>	
14. MOTHER'S MAIDEN NAME <u>NANCY MUMFORD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>16</u>		17. INFORMANT <u>Mrs. R.M. HUDSON</u> Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of urinary bladder</u> DUE TO (c) <u>2 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 1957 to <u>Dec. 10</u> , 1959, that I last saw the deceased alive on <u>Dec. 11</u> , 1959, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Raymond M. Yow</u> M.D. <u>707 Camden Ave. Salisbury Md. 12-11-59</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>O.U.A.M.</u>	22d. LOCATION (City, town, or county) (State) <u>MILLSBORO DEL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne D. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

11330

TECHNICAL PROGRAM

11331



ANNEX 1

11332

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14300

14355

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardella</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> <u>09X-2</u> ✓ d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> First <u>Franklin</u> Middle <u>Hughes</u> Last				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>12</u> Year <u>1959</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/29/1898</u>		<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Catch. Const. Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Elijah Hughes</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Spencer</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Mr. Leon Hughes</u> Address <u>Vienna Md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u> <span style="float: right;">M.D.</span>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>12-16-59</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>12/16/59</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>East New Market</u>				<b>22d. LOCATION (City, town, or county)</b> <u>East New Market, Md</u> <span style="float: right;">(State)</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Kline</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DEC 24 '59</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED [REDACTED]</p>		<p>AGE [REDACTED]</p>	
<p>SEX [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>	
<p>PLACE OF DEATH [REDACTED]</p>		<p>CAUSE OF DEATH [REDACTED]</p>	
<p>DATE OF EXAMINATION [REDACTED]</p>		<p>TIME OF EXAMINATION [REDACTED]</p>	
<p>NAME OF EXAMINER [REDACTED]</p>		<p>ADDRESS OF EXAMINER [REDACTED]</p>	
<p>NAME OF DECEASED [REDACTED]</p>		<p>AGE [REDACTED]</p>	
<p>SEX [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>	
<p>PLACE OF DEATH [REDACTED]</p>		<p>CAUSE OF DEATH [REDACTED]</p>	
<p>DATE OF EXAMINATION [REDACTED]</p>		<p>TIME OF EXAMINATION [REDACTED]</p>	
<p>NAME OF EXAMINER [REDACTED]</p>		<p>ADDRESS OF EXAMINER [REDACTED]</p>	
<p>NAME OF DECEASED [REDACTED]</p>		<p>AGE [REDACTED]</p>	
<p>SEX [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>	
<p>PLACE OF DEATH [REDACTED]</p>		<p>CAUSE OF DEATH [REDACTED]</p>	
<p>DATE OF EXAMINATION [REDACTED]</p>		<p>TIME OF EXAMINATION [REDACTED]</p>	
<p>NAME OF EXAMINER [REDACTED]</p>		<p>ADDRESS OF EXAMINER [REDACTED]</p>	



14323

CERTIFICATE OF DEATH

Reg. Dist. No.

14301

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Wicomico</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				/d. STREET ADDRESS <b>Ocean City Blvs.,</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WALTER</b> Last <b>JACKSON, Sr.</b>				4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 17, 1894</b>		9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Campbell Soup</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>S Gerturde P rker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>212-09-5171</b>		17. INFORMANT <b>Mrs. J. Walter Jackson, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Broncho, Entire Pt of lung</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 wk.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/5/59</b> to <b>12/6/59</b> , that I last saw the deceased alive on <b>12/6/59</b> , and that death occurred at <b>4:58</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Refuss Gardner Jr</b> M.D.				ADDRESS (Street, city or town, state) <b>PINEbluff Rd. Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>ROFUSS GARDNER JR</b>				DATE SIGNED <b>12/7/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonsbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REGISTERED BY REGISTRAR DATE <b>DEC 9 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Franz</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Turpin Farm(N.of City)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>UPSHUR</b> Middle <b>VADEN</b> Last <b>LEWIS</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>2nd</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 9, 1888</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Brickmason</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>brick Layer</b>		11. BIRTHPLACE (State or foreign country) <b>Accomac County-Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Raymond Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Susie C. Lewis (Wife)</b>				Address <b>320 Naylor St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>year</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11332

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1950		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Examiner		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14324

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mallard Island, Ocean City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>23X-2</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Hastings</b> Last <b>Lynch</b>			4. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1942</b>	9. AGE (In years last birthday) <b>17</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13. FATHER'S NAME <b>C. EVERETT LYNCH</b>		14. MOTHER'S MAIDEN NAME <b>NANCY HARWOOD</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>MR. WILLIAM LYNCH</b> Address <b>OCEAN CITY, MD</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2 + 3rd degree burns</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in collision and fire.</b>		
20c. TIME OF INJURY Month, Day, Year Hour <b>5 PM</b> a.m. <b>12-25-59</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route #50</b>	20f. (City or town) (County) (State) <b>Ocean City Worcester Md.</b>

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <b>Earl L. Royer</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>12-29-59</b>
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	22d. LOCATION (City, town, or county) (State) <b>Berlin Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burboze</b>		ADDRESS <b>Berlin Md</b>	24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







14325

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>87 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City Sub. Brooklyn Park</u> <u>0250-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>311 Fifth Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Matilda (Tillie)</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-95</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min.		11. IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Flynn</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		INFORMANT <u>Deer's Head Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pulmonary congestion</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> Years (c) <u>Arteriosclerosis, general</u> Years						INTERVAL BETWEEN ONSET AND DEATH <u>48</u> hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-7, 1957</u> to <u>12-29, 1959</u> , that I last saw the deceased alive on <u>12-29, 1959</u> , and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>12-30-59</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Ponce</u>		ADDRESS <u>4001 Ritchie Hwy. Bkts</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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091

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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

14387

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14326

## CERTIFICATE OF DEATH

Reg. Dist. No. 14377

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>1506 CAMDEN AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ann</u> Last <u>McDonnell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 15, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN DEAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CALLAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>025-20-0514</u>	
17. INFORMANT <u>MARGURITE McDONNELL</u>		Address <u>- SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Diabetes Mellitus</u> DUE TO <u>Coronary Thrombosis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>12/31/59</u> , that I last saw the deceased alive on <u>12/31/59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>12-31-59</u> ACTUAL SIGNATURE <u>A.C. Mitchell</u> M.D. PHYSICIAN'S NAME (Type) <u>A.C. Mitchell</u> <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/21/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Woburn</u>	22d. LOCATION (City, town, or county) (State) <u>Woburn, Mass.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hilly Johnson Co., Salisbury, Md.</u> <u>Burge C. Nye</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

1935

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "WHEREAS" and "AND" are visible.]*

14327

## CERTIFICATE OF DEATH

Reg. Dist. No. 14305

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>				c. LENGTH OF STAY IN 1b <u>209 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEER'S HEAD STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-77</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Mills</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Harmon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Deer's Head Records</u>				Address <u>Deer's Head Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate gland with generalized metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease.</u> (c) _____ DUE TO _____ DUE TO _____ DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>  Years _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>5-7-</u> , 19 <u>59</u> , to <u>12-2</u> , 19 <u>59</u> , that I lost the deceased alive on <u>12-2-</u> , 19 <u>59</u> , and that death occurred at <u>6 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>12-2-59</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				(Deer's Head State Hospital)			
22a. BYRIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec 6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Salisbury, Md</u>				22e. REC'D BY REGISTRAR <u>Shoultz</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton</u>				24. DATE <u>DEC 7 '59</u>			

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## CERTIFICATE OF DEATH

14306

Reg. Dist. No.

14357

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 5 Quantico Rd</b>		d. STREET ADDRESS <b>R.D.# 5 Quantico Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>WINFIELD</b> Middle <b>THEOPOLIS</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>9th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1878</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>6</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Quantico Md. (Wico Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Monelius J. Mills</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hester Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Maude E. Mills (Wife) R.D.# 5 Quantico Rd. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Arterio sclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>10 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>15 March, 1949</b> , to <b>10 Dec., 1959</b> that I last saw the deceased alive on <b>10 Dec., 1959</b> , and that death occurred at <b>12:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hebron, Md.</b> DATE SIGNED <b>Dec. 11, 1959</b> ACTUAL SIGNATURE <b>Richard H. Saunders</b> PHYSICIAN'S NAME (Type) <b>Dr. Richard H. Saunders</b> <b>Hebron, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF THE ATTORNEY GENERAL

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14328

Item 7 FilmG253 12-22-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

14307

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury</u> d. STREET ADDRESS <u>Route 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>John B. Mitchell</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>December 5 1959</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5-20-78</u>	
<b>9. AGE</b> (In years last birthday) yrs. <u>81</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>11. IF UNDER 24 HRS.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labor</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Parsonsbury md</u>	
<b>13. FATHER'S NAME</b> <u>Ebenezer Mitchell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Turnell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>221-09-3645</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Accident</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Renal</u> DUE TO (c) <u>Indefinite</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 weeks</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>13 Nov. 1959</u> <b>to</b> <u>5 Dec. 1959</u> <b>that I last saw the deceased alive on</b> <u>4 Dec. 1959</u> <b>and that death occurred at</b> <u>5:12 AM</u> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>Turnell</u> <b>M.D.</b> <u>Salisbury, Md</u> <b>DATE SIGNED</b> <u>5 Dec 59</u>							
<b>PHYSICIAN'S NAME (Type)</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-10-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bloss Hill Cem</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Parsonsbury md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Booker McLeary</u>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 18 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1901

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Back of National Guard Armory</b>				d. STREET ADDRESS <b>915 N. Division St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>EDWARD</b> Last <b>MURRELL</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>10th</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Spring Hill Sanitarium</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>(Nursing Home)</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John Robert Murrell</b>				14. MOTHER'S MAIDEN NAME <b>Malenda S. Noble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Frances P. Murrell (Wife) 915 N. Div. St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CO Poisoning</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>stating the underlying cause last.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None from exhaust to car</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None from exhaust to car</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>6 p.m.</b> <b>12 10 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At 50</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				DATE SIGNED <b>Dec. 11 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>			
24a. REC'D BY REGISTRAR <b>DEC 14 58</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15



## CERTIFICATE OF DEATH

Reg. Dist. No.

14309

14358

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			c. LENGTH OF STAY IN 1b <b>17 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hebron</b>				d. STREET ADDRESS <b>Rt</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>PHILLIPS</b>				4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2, 1869</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Lumberman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John P. Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Bounds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT Name <b>Mrs. David J. Ward Jr.</b> Address <b>Salisbury</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Do generalized Heart Disease</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11</b> , 19 <b>58</b> , to <b>12-22-1959</b> , that I last saw the deceased alive on <b>12-22</b> , 19 <b>59</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William R. Ellis</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>12-23-59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis, Jr. Medical Center</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  JAMES H. HARRIS</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  37.7 yrs</p>		<p>4. RACE                  White</p>		<p>5. MARRIAGE                  Married</p>		<p>6. OCCUPATION                  Clerk</p>	
<p>7. PLACE OF BIRTH                  Baltimore, Md.</p>		<p>8. PLACE OF DEATH                  Baltimore, Md.</p>		<p>9. DATE OF DEATH                  Jan 10, 1912</p>		<p>10. TIME OF DEATH                  10:30 AM</p>		<p>11. CAUSE OF DEATH                  Myocardial Infarction</p>		<p>12. MANNER OF DEATH                  Natural</p>	
<p>13. SIGNATURE OF DECEASED                  (None)</p>		<p>14. SIGNATURE OF NEXT OF KIN                  J. H. Harris</p>		<p>15. SIGNATURE OF PHYSICIAN                  J. H. Harris</p>		<p>16. SIGNATURE OF CORONER                  J. H. Harris</p>		<p>17. SIGNATURE OF REGISTRAR                  J. H. Harris</p>		<p>18. SIGNATURE OF CLERK                  J. H. Harris</p>	
<p>19. PLACE OF INTERMENT                  St. James Church</p>		<p>20. NAME OF INTERMENT SOCIETY                  St. James Church</p>		<p>21. NAME OF MINISTER                  St. James Church</p>		<p>22. NAME OF CHURCH                  St. James Church</p>		<p>23. NAME OF CEMETERY                  St. James Church</p>		<p>24. NAME OF FUNERAL HOME                  St. James Church</p>	
<p>25. NAME OF FUNERAL HOME                  St. James Church</p>		<p>26. NAME OF FUNERAL HOME                  St. James Church</p>		<p>27. NAME OF FUNERAL HOME                  St. James Church</p>		<p>28. NAME OF FUNERAL HOME                  St. James Church</p>		<p>29. NAME OF FUNERAL HOME                  St. James Church</p>		<p>30. NAME OF FUNERAL HOME                  St. James Church</p>	

1. NAME OF DECEASED  
 JAMES H. HARRIS

2. SEX  
 Male

3. AGE  
 37.7 yrs

4. RACE  
 White

5. MARRIAGE  
 Married

6. OCCUPATION  
 Clerk

7. PLACE OF BIRTH  
 Baltimore, Md.

8. PLACE OF DEATH  
 Baltimore, Md.

9. DATE OF DEATH  
 Jan 10, 1912

10. TIME OF DEATH  
 10:30 AM

11. CAUSE OF DEATH  
 Myocardial Infarction

12. MANNER OF DEATH  
 Natural

13. SIGNATURE OF DECEASED  
 (None)

14. SIGNATURE OF NEXT OF KIN  
 J. H. Harris

15. SIGNATURE OF PHYSICIAN  
 J. H. Harris

16. SIGNATURE OF CORONER  
 J. H. Harris

17. SIGNATURE OF REGISTRAR  
 J. H. Harris

18. SIGNATURE OF CLERK  
 J. H. Harris

19. PLACE OF INTERMENT  
 St. James Church

20. NAME OF INTERMENT SOCIETY  
 St. James Church

21. NAME OF MINISTER  
 St. James Church

22. NAME OF CHURCH  
 St. James Church

23. NAME OF CEMETERY  
 St. James Church

24. NAME OF FUNERAL HOME  
 St. James Church

25. NAME OF FUNERAL HOME  
 St. James Church

26. NAME OF FUNERAL HOME  
 St. James Church

27. NAME OF FUNERAL HOME  
 St. James Church

28. NAME OF FUNERAL HOME  
 St. James Church

29. NAME OF FUNERAL HOME  
 St. James Church

30. NAME OF FUNERAL HOME  
 St. James Church

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 14 Film G254 1-8-60 et  
14330  
CERTIFICATE OF DEATH

Reg. Dist. No. 14310

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General</u>				d. STREET ADDRESS <u>1243 V St., S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>PROHASKA</u> Last <u>PIEFER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 2, 1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES PROHASKA</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-01-6320</u>		INFORMANT Address <u>MRS. W. T. Booth - Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 330 X DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>12/25/59</u> , 19 <u>  </u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>Dec. 25, 1959</u>			
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>				<u>SALISBURY, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/28/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HILL &amp; JOHNSON Co. Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

Burial Certificate

CERTIFICATE OF DEATH

14330

Blank form area with faint horizontal lines for text entry.

Vertical text on the right margin, possibly a date or reference number, including "JAN 10 1911".

14331

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardella Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore</u> First <u>Pinkett</u> Middle <u>Pinkett</u> Last			4. DATE OF DEATH <u>December 4</u> 19 <u>59</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1908</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Alex Pinkett</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-83-4180</u> INFORMANT <u>Jaygo Pinkett</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREmia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Cardio-Renal disease</u> DUE TO <u>2 yr.</u> (c) <u>chronic glomerulonephritis</u> DUE TO <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>59</u> , to <u>Dec. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 4</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond M. Gown</u>				ADDRESS (Street, city or town, state) <u>707 Camden Ave. Salisbury, md</u> DATE SIGNED <u>12-5-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Becker M. West</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

14341

NEW YORK'S ALLIANCE OF NEW YORKERS IS

CELEBRATING THE 100TH

14341





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14332**  
**CERTIFICATE OF DEATH**

14312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>713 S.Division St</b>		d. STREET ADDRESS <b>713 S.Division St</b>	
3. NAME OF DECEASED (Type or print) <b>HATTIE</b> First Middle Last		4. DATE OF DEATH <b>DEC. 22nd 1959</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR <b>11</b> Months <b>10</b> Days <b>10</b> Hours <b></b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>White Haven Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>* * * * * Denson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wesley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mr William R. Dryden (Son) 412 Monticello Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO <b>Cause undetermined as patient was expiring upon arrival of the Physician, Baltimore, Thunders...</b> DUE TO <b>or embolus ???</b> (b) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/23/59</b> , 19, and that death occurred at <b>10:30 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>Dec. 23, 1959</b> ACTUAL SIGNATURE <b>Carrie I. Hearn</b> M.D. <b>N. Division St. Salisbury, Maryland</b> PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

11

MALE  
BORN [illegible]  
DIED [illegible]  
CAUSE OF DEATH [illegible]  
PLACE OF DEATH [illegible]  
DATE OF DEATH [illegible]  
SIGNATURE OF REGISTRAR [illegible]  
LOCALITY [illegible]  
COUNTY [illegible]  
STATE [illegible]

14333

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reynolds General</u>		d. STREET ADDRESS <u>19X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>A</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Mond</u>		14. MOTHER'S MAIDEN NAME <u>Emma Faye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-0788</u>	
17. INFORMANT <u>Mr. C. R. Payne</u>		Address <u>Princess Anne MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Myocardium &amp; Hemopericardium</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic C.V. disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 days?</u> <u>? years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis of Middle cerebral artery left.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>25 Nov.</u> , 19 <u>59</u> , to <u>9 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Dec</u> , 19 <u>59</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald M.D.</u>		ADDRESS (Street, city or town, state) <u>707 Camden Ave</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>		DATE SIGNED <u>10 Dec 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rehoboth Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Rehoboth, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leona B. Williams</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1931



14359

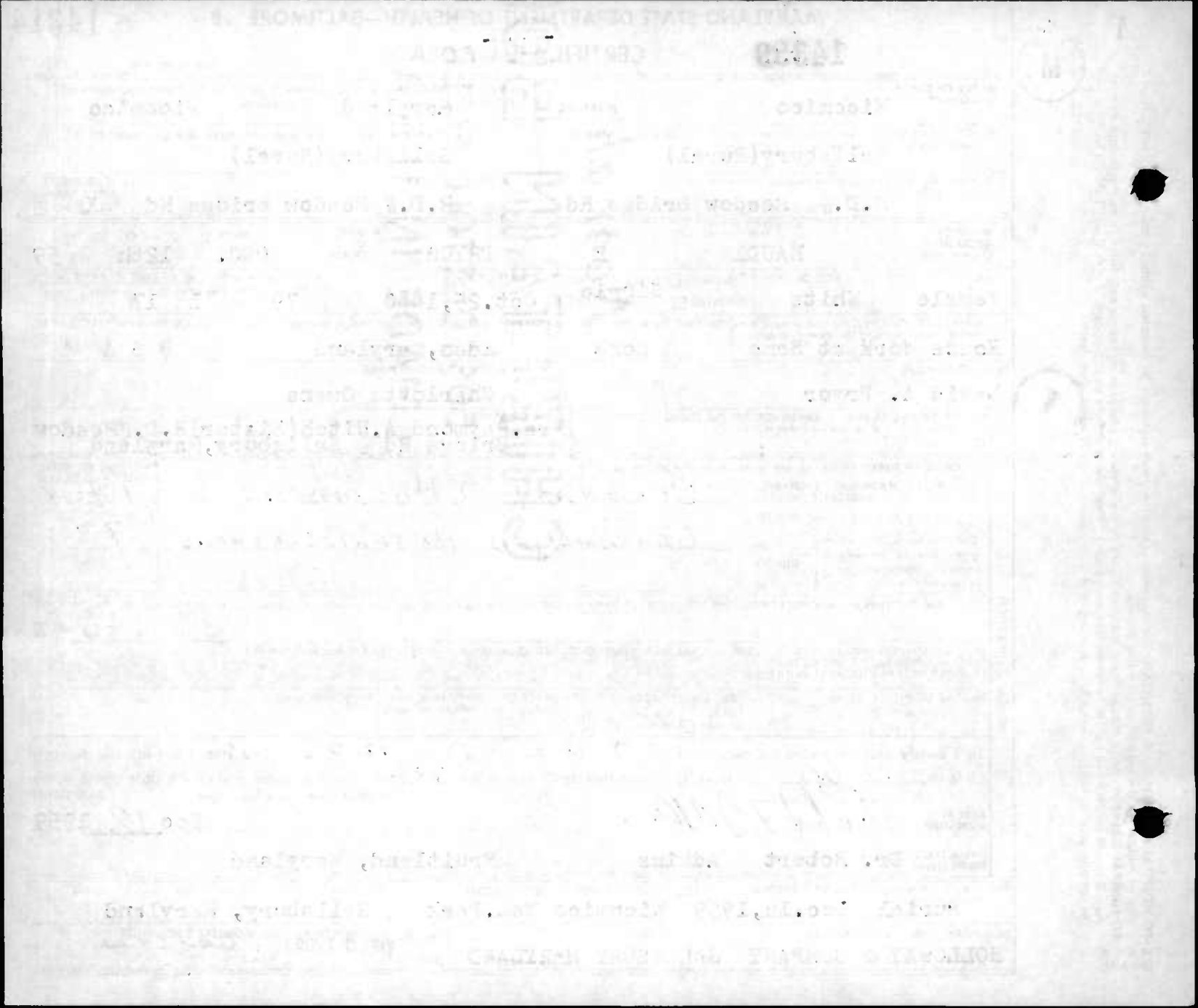
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury(Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury(Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# Meadow Bridge Rd</b>		d. STREET ADDRESS <b>R.D.# Meadow Bridge Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>E</b> Last <b>PRYOR</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>12th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b>	8. DATE OF BIRTH <b>Oct. 25, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Eden, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>David A. Pryor</b>	
14. MOTHER'S MAIDEN NAME <b>Charlotte Owens</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Mrs. Raymond A. Hitch (Sister) R.D.# Meadow Bridge Rd Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 Dec</b> , 19 <b>59</b> , to <b>12 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12 Dec</b> , 19 <b>59</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dec 12 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert T. Adkins</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Robert Adkins Fruitland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	24a. REC'D BY REGISTRAR <b>DEC 17 59</b> DATE
24b. REGISTRAR'S SIGNATURE <b>Robert A. Adams</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
14334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>517 Alabama Ave.</b>		d. STREET ADDRESS <b>517 Alabama Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY (MOLLIE) CATHERINE PURCELL</b>		4. DATE OF DEATH <b>DEC. 2nd 19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1877</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR <b>0</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>C. Columbus Fields</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Rigger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Martha Townsend (Daughter) 711 Taylor St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Congestion</b> DUE TO <b>Hypertension C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial</b>		22b. DATE THEREOF <b>Dec. 6, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14335

CERTIFICATE OF DEATH

Reg. Dist. No. 14316

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clinton Edmond Guillen</u>				4. DATE OF DEATH <u>DECEMBER 30</u> 19 <u>59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 26, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR <u>11</u> Months		IF UNDER 24 HRS. <u>11</u> Days		Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEED MFG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL M. GUILLIN</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA DERRICKSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-10-7461</u>		INFORMANT <u>MRS. C.E. GUILLIN,</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage due to</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 30</u> , 19 <u>59</u> , to <u>Dec 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff, Md</u> DATE SIGNED <u>12/30/59</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>				<u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem.</u>		22d. LOCATION (City, town, or county) <u>BERLIN, MARYLAND</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; JOHNSON Co.</u> ADDRESS <u>SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR <u>JAN 6 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

14336

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>604 Smith St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WILLIAM</u> Last <u>RALPH</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>7</u> Hours <u>12</u> Min. <u>15</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant-Clothing Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel, Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Handy Ralph</u>		14. MOTHER'S MAIDEN NAME <u>Emma Horsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Miss Grace Ellingsworth (Sister-In-Law)</u> <u>604 Smith St. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X</u> DUE TO <u>Cot pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchitis</u> DUE TO <u>Unknown</u> (c) <u>Pulmonary emphysema</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5, 1959</u> to <u>Dec 7, 1959</u> that I last saw the deceased alive on <u>Dec 7, 1959</u> and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center <u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14337

## CERTIFICATE OF DEATH

Reg. Dist. No.

14318

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <del>MA</del> <b>Virginia</b> COUNTY <b>Northumberland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>App: 1-Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Private Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LELA</b> Middle <b>CATHERINE</b> Last <b>RAWLINGS</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>27th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Northumberland Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Howell Blunden</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Downing Nelms</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. W. Ray Phillips (sister)</b> Address <b>733 Camden Ave. Salisbury, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b> <b>Arterial Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>12/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/27</b> , 19 <b>59</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>Dec. 30, 1959</b> ACTUAL SIGNATURE <b>Fred R. Gramse</b> M.D. <b>Salisbury, Md.</b> PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b> <b>S. Division St. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

STATE OF TEXAS

1933

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>RFD # 3</b>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>C.</b> Last <b>Redden</b>				4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>59</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 13, 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>23</b> Days <b>x</b>		IF UNDER 24 HRS. Hours <b>2</b> Min. <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Peter Pruitt</b>				14. MOTHER'S MAIDEN NAME <b>Mary Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>--</b>		17. INFORMANT <b>R.F.D. 3</b> <b>Franklin P. Redden, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral Circulatory Failure</b> DUE TO <b>Fracture left femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>902.0</b> (c) <b>2 days</b> <b>2 days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>23</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell getting out of bed during night</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:30 P.M. 12-20</b>		20d. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>		20f. (City or town) (County) (State) <b>Pocomoke Worcester Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12-23-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-59</b>		22c. NAME OF CEMETERY <b>First Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry B. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



14339

CERTIFICATE OF DEATH

Reg. Dist. No.

14320

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS DILLARD Riley</u>		4. DATE OF DEATH Month Day Year <u>December 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 1, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH CARSON RILEY</u>		14. MOTHER'S MAIDEN NAME <u>ALICE BREWER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-16-4510</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of bladder</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1959</u> to <u>December 14, 1959</u> , that I last saw the deceased alive on <u>December 14, 1959</u> , and that death occurred at <u>6:53 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12-15-59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>DORSEY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry B. Watson</u> ADDRESS <u>POCOMOKE CITY, MD</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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OFFICE OF THE ATTORNEY GENERAL

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14340

## CERTIFICATE OF DEATH

Reg. Dist. No. 14321

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>R.D.# 3 (Marvel Rd)</b>	
3. NAME OF DECEASED (Type or print) First <b>DINA</b> Middle <b>RAY</b> Last <b>ROSEN</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>8th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Baby</b>	8. DATE OF BIRTH <b>Dec. 8, 1959</b>
9. AGE (In years last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Mins <b>21</b>	IF UNDER 24 HRS. <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Clyde Fulton Rosen</b>	
14. MOTHER'S MAIDEN NAME <b>Jeanette Francis Brittingham</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. ADDRESS <b>Mr. Clyde F. Rosen - Father - R.D.# 3 (Marvel Rd) Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0 Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>762.0</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Gallaher</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>Dec. 10 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James P. Gallaher</b>		<b>Medical Center Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1930

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MASSACHUSETTS  
BUREAU OF VITAL RECORDS  
DECEASED  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Buried: [illegible]  
Interment: [illegible]  
Funeral Home: [illegible]  
Physician: [illegible]  
Coroner: [illegible]  
Registrar: [illegible]  
County: [illegible]  
City: [illegible]  
Town: [illegible]  
Village: [illegible]  
Street: [illegible]  
House No.: [illegible]  
Room No.: [illegible]  
Occupation: [illegible]  
Marital Status: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Parents: [illegible]  
Siblings: [illegible]  
Education: [illegible]  
Religion: [illegible]  
Political Party: [illegible]  
Military Service: [illegible]  
Awards: [illegible]  
Notes: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14322

14341

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula Hospital</b>		e. STREET ADDRESS <b>202 Hayward St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Ottie</b> Middle <b>Warren</b> Last <b>Ruark</b>		4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Bishops Head, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Ruark</b>		14. MOTHER'S MAIDEN NAME <b>Mary Murphy</b>	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-0420</b>	
17. INFORMANT <b>Phillip L. Ruark</b>		Address <b>97 Phillips Ave., Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branch pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subarachnoid hemorrhage - traumatic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>year</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fall out of bed at home</b>	
20c. TIME OF INJURY Hour <b>8</b> a.m. <b>12</b> p.m. Month, Day, Year <b>12 24 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Cambridge Dorchester Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>		DATE SIGNED <b>12-31-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 2, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thow</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thow</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

14323

14342

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>276</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEER'S HEAD STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle Last <u>Scott</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>worked in tomato factory</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Ernest Scott</u>				14. MOTHER'S MAIDEN NAME <u>Attie Journal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-I4-7824</u>			
17. INFORMANT <u>Deer's Head Rdcords</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm of ascending aorta</u> 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Luetic cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of stomach.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.?</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>o. m.</u> <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2</u> , 19 <u>59</u> , to <u>Dec. 3</u> , 19 <u>59</u> , and that death occurred at <u>10:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>12-4-59</u>							
ACTUAL SIGNATURE <u>J. Juerman</u>				PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
22d. LOCATION (City, town, or county) <u>Princess Anne, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>				ADDRESS <u>Princess Anne, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

123456



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.





14360

## CERTIFICATE OF DEATH

14324

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELLA SPRINGS</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE SHADE NURSING HOME</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>-</u> Last <u>SHARP</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 18 1872</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William SHARP</u>				14. MOTHER'S MAIDEN NAME <u>MARY TAPMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT Address <u>MRS. FLOYD DEAN, CENTREVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dehydration + emphysema</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Hour <u>10</u> o. m. <u>12 25</u> p. m. <u>1959</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>before death 12/25, 1959</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>59</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Elliott</u>				ADDRESS (Street, city or town, state) <u>114 West St. Laurel MD</u>			
PHYSICIAN'S NAME (Type) <u>J. A. Elliott MD</u>				DATE SIGNED <u>12/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. H. Connelley</u>				ADDRESS <u>Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Haines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14325

14343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>17 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Helm</b> Last <b>Short</b>				4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 19, 1876</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William D. Short</b>				14. MOTHER'S MAIDEN NAME <b>Olivia Lankford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>782.4</b>			
17. INFORMANT <b>Hospital Records - Salisbury, Maryland</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arthritis of Knee Joints.</b> DUE TO (c) <b>Emphysema Multiple Decubitus Ulcers State after Fracture of Right Femur Osteo-</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis of Knee Joints.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/9/</b> , 19 <b>59</b> , to <b>12/26/</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/26/</b> , 19 <b>59</b> , and that death occurred at <b>1:50 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Kosmahly</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>			
DATE SIGNED <b>12/26/59</b>							
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>				22b. DATE THEREOF <b>12/29/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>				22d. LOCATION (City, town, or county) (State) <b>Hurlock, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith S. Trillory</b>				ADDRESS <b>East New Market</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				24c. REC'D BY REGISTRAR <b>DEC 29 1959</b>			

M

091

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MEDICAL CERTIFICATION

1

BP

14328

CERTIFICATE OF DEATH

14328

40

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>---</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>PATRICIA</b> Last <b>STURGIS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1907</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank A. Scott</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Garrett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>280-14-1540</b>	
17. INFORMANT <b>T. Donald Sturgis, Franklin City, Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 252.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Toxic Heart Disease - fibrillation</b> DUE TO (c) <b>Thyrotoxicosis - Graves disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 23, 1959</b> to <b>Dec 24, 1959</b> , that I lost saw the deceased alive on <b>Dec 24, 1959</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Cohen</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>12-26-59</b>	
PHYSICIAN'S NAME (Type) <b>Paul Cohen</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-28-59</b>	
22c. NAME OF CEMETERY <b>Spring Hill Mem. Garden</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1910-01-01		1955-03-15		Home		Heart Disease		Coronary Artery Disease		John Doe, M.D.		John Doe, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Jane Smith		32		Female		White		1923-05-10		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Jane Smith, M.D.		Jane Smith, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Robert Johnson		58		Male		White		1897-08-20		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Robert Johnson, M.D.		Robert Johnson, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Mary White		65		Female		White		1890-03-05		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Mary White, M.D.		Mary White, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
James Brown		72		Male		White		1883-01-15		1955-03-15		Home		Heart Disease		Coronary Artery Disease		James Brown, M.D.		James Brown, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Elizabeth Green		55		Female		White		1900-06-01		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Elizabeth Green, M.D.		Elizabeth Green, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
William Black		68		Male		White		1887-09-10		1955-03-15		Home		Heart Disease		Coronary Artery Disease		William Black, M.D.		William Black, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Margaret White		78		Female		White		1877-02-20		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Margaret White, M.D.		Margaret White, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Charles Brown		85		Male		White		1870-04-05		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Charles Brown, M.D.		Charles Brown, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Anna Green		92		Female		White		1863-07-15		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Anna Green, M.D.		Anna Green, M.D.	
Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Disease		Signature of Physician		Signature of Registrar	
Thomas Black		98		Male		White		1857-11-01		1955-03-15		Home		Heart Disease		Coronary Artery Disease		Thomas Black, M.D.		Thomas Black, M.D.	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14327

Reg. Dist. No.

14361

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> c. LENGTH OF STAY IN 1b <u>unknown</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Unknown</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Unknown</u> b. COUNTY <u>Unknown</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Unknown</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>20</u> Year <u>59</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12-20-59</u>		<b>9. AGE</b> (In years last birthday) <u>few</u> yrs. <u>  </u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country)				<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)				<b>17. INFORMANT</b> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Prematurity</u>  <u>776X</u>  <b>DUE TO</b>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> <b>(b)</b>  <b>DUE TO</b> <u>  </u> <b>(c)</b> </div>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Minutes</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter date of injury in Part I of Part II of item 18.) <u>Body with placenta attached. Found dead in plastic bag on dump.</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>2</u> Hour <u>a. m.</u> <u>1220</u> <u>1959</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				<b>20f. (City or town)</b> <u>Fruitland</u> <u>Wicomico</u> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u> <b>M.D.</b>								<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer, M.D.</u>								<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>12-24-59</u>								<b>DATE SIGNED</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>12/26/1959</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PARSONS CEMETERY</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Salisbury</u> <u>Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Herbert Wallace</u>								<b>ADDRESS</b> <u>Salisbury, Ind.</u>							
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 29 '59</u>								<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. K...</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		M		W		1918		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF BURIAL	
100 N. ST.		LABORER		HEART DISEASE		NATURAL		10:00 AM		CATHOLIC CHURCH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
1913		MASSACHUSETTS		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF BURIAL	
1918		BOSTON		HEART DISEASE		NATURAL		10:00 AM		CATHOLIC CHURCH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
1913		MASSACHUSETTS		HIGH SCHOOL		MARRIED		NONE		NONE	

## CERTIFICATE OF DEATH

Reg. Dist. No.

14328

14345

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 Wk.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>BURLEY ST</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK LEWIS VOYCE</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 20 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 20 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>BAXION, PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MARK VOYCE</u>				14. MOTHER'S MAIDEN NAME <u>CORA LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>216-16-7687</u>			
17. INFORMANT <u>MRS. F.L. VOYCE</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12-19</u> , 19 <u>59</u> , to <u>12-20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>59</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>12-20-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdige</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE

1918

REPORT OF THE

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14378

14362

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs - Rural</b>				c. LENGTH OF STAY IN 1b <b>2 yrs. 18 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Robert</b> Last <b>Wainwright</b>				4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. NAME OF FATHER <b>Nathaniel Wainwright</b>				14. MOTHER'S MAIDEN NAME <b>Vashie Marine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>G. Garland Wainwright, Rhodesdale, Md., RFD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Distention</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>54 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July, 1957</b> , to <b>Dec 25, 1959</b> , that I last saw the deceased alive on <b>Dec 25, 1959</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuhlman</b>				ADDRESS (Street, city or town, state) <b>Sharptown, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>H. S. Kuhlman</b>				DATE SIGNED <b>12-26-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brookview, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14363

REG. NO. 14363

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1890		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
Carpenter		Myocardial Infarction		Natural		2 weeks		JAN 10 1935		10:30 AM		BALTIMORE		MD	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		DIAGNOSIS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS	
None		Chest pain, shortness of breath		None		Myocardial Infarction		None		None		None		None	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF PHYSICIAN		DATE	
JAN 10 1935		10:30 AM		BALTIMORE		MD		USA		None		JAMES H. HARRIS		JAN 10 1935	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

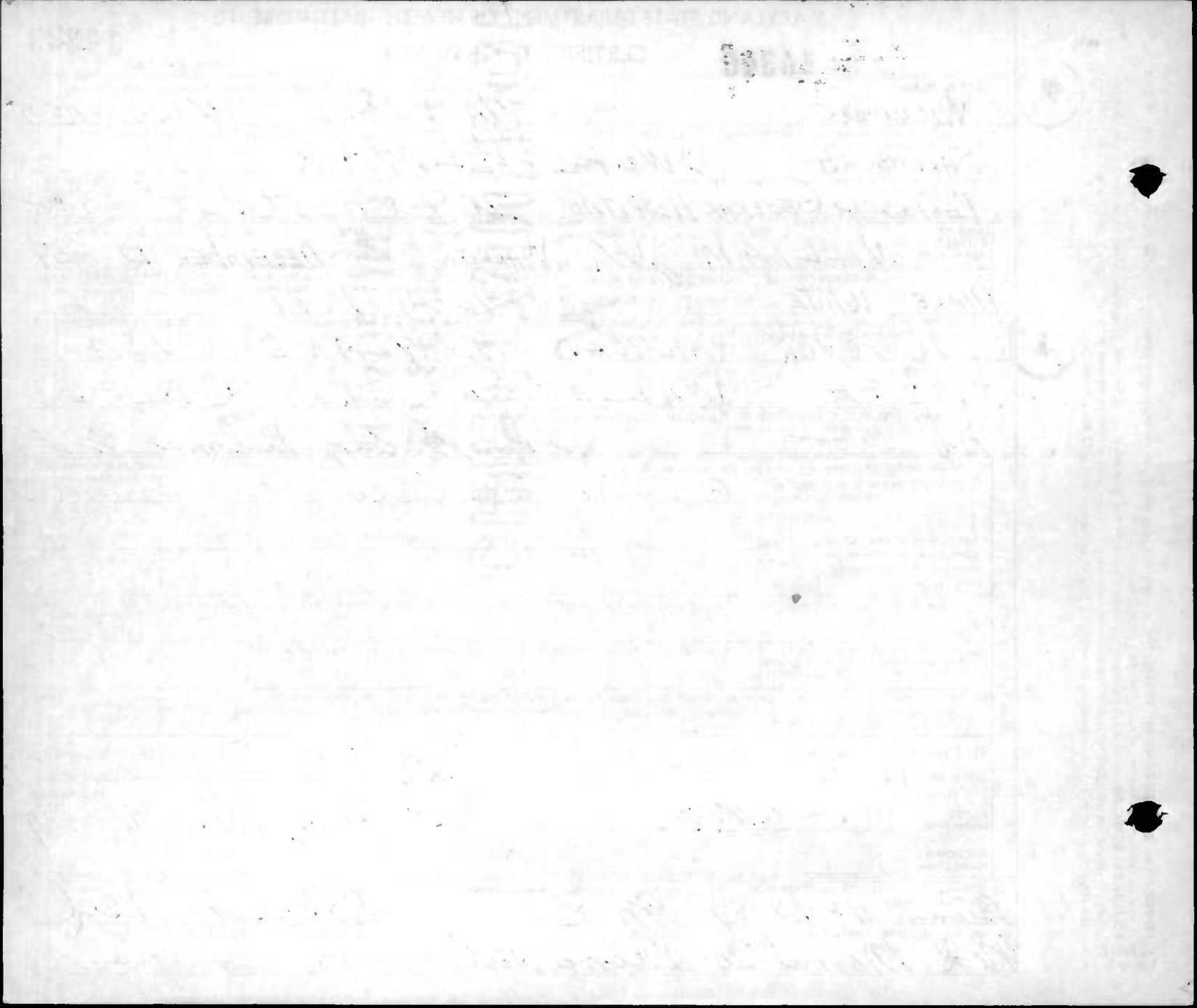
14329

14346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>209 CHESTNUT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM W. WALLER</u>		First Middle Last		4. DATE OF DEATH <u>DECEMBER 12 1959</u>		Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH</u>		14. MOTHER'S MAIDEN NAME <u>WALLER MARGARET GOSLEE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Era Waller, Delmar Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-26</u> , 19 <u>59</u> to <u>12-12</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-12</u> , 19 <u>59</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Waller</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>					
PHYSICIAN'S NAME (Type) <u>W. S. Marshall Co - Delmar, Del.</u>		DATE <u>DEC 21 '59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Delmar</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co - Delmar, Del.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14331

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

14363

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. LENGTH OF STAY IN 1b <b>7 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>165 Shelton Ave.,</b>				d. STREET ADDRESS <b>165 Shelton</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Samuel</b> Last <b>Webb</b>				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1910</b>		9. AGE (In years last birthday) <b>49 yrs.</b>	10. IF UNDER 1 YEAR Months <b>49</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sewell Emerson Webb</b>				14. MOTHER'S MAIDEN NAME <b>Laura Denson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Elizabeth Webb, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot gun wound of brain</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with Shotgun</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>12:10</b> a.m. <b>12 5</b> 19 <b>59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Fruitland Wicomico Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fruitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Klaus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
STATE OF MARYLAND  
HEALTH DEPT.

11-1863

1. NAME OF DECEASED: [illegible]  
2. RESIDENCE: [illegible]  
3. OCCUPATION: [illegible]  
4. CAUSE OF DEATH: [illegible]

5. PLACE OF DEATH: [illegible]  
6. DATE OF DEATH: [illegible]  
7. TIME OF DEATH: [illegible]

8. SEX: [illegible] 9. AGE: [illegible]  
10. COLOR: [illegible] 11. BIRTH DATE: [illegible]

12. MARITAL STATUS: [illegible] 13. EDUCATION: [illegible]  
14. RELIGION: [illegible] 15. PREVIOUS ILLNESS: [illegible]

16. SIGNATURE OF EXAMINER: [illegible]  
17. DATE OF EXAMINATION: [illegible]

18. SIGNATURE OF WITNESS: [illegible]  
19. DATE OF WITNESSING: [illegible]

20. SIGNATURE OF CORONER: [illegible]  
21. DATE OF CORONER'S SIGNATURE: [illegible]

22. SIGNATURE OF JURY: [illegible]  
23. DATE OF JURY'S SIGNATURE: [illegible]

24. SIGNATURE OF JUDGE: [illegible]  
25. DATE OF JUDGE'S SIGNATURE: [illegible]

26. SIGNATURE OF CLERK: [illegible]  
27. DATE OF CLERK'S SIGNATURE: [illegible]

28. SIGNATURE OF ASSISTANT CLERK: [illegible]  
29. DATE OF ASSISTANT CLERK'S SIGNATURE: [illegible]

30. SIGNATURE OF DEPUTY CLERK: [illegible]  
31. DATE OF DEPUTY CLERK'S SIGNATURE: [illegible]

32. SIGNATURE OF CHIEF CLERK: [illegible]  
33. DATE OF CHIEF CLERK'S SIGNATURE: [illegible]

34. SIGNATURE OF SECRETARY: [illegible]  
35. DATE OF SECRETARY'S SIGNATURE: [illegible]

36. SIGNATURE OF ASSISTANT SECRETARY: [illegible]  
37. DATE OF ASSISTANT SECRETARY'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14347

## CERTIFICATE OF DEATH

Reg. Dist. No.

14330

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>19x.2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne, Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Beatrice White</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 16 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1909</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>44 yrs</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. FATHER'S NAME <u>Litton Miles</u>		16. MOTHER'S MAIDEN NAME <u>Minnie Cursey</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		18. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Embery White Princess Anne, Md</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Dis.</u> DUE TO <u>44 yrs</u> (c) <u>Diabetes - Gangrene of toes</u> DUE TO <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 16, 1959</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>59</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Princess Anne, Md</u> DATE SIGNED <u>12/18/59</u> ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D. PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Green Hill, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u> ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles B. James</u>

CERTIFICATE OF DEATH

1934

1

1





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14332

14348

Item 8. See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pen Sen Hosp.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Wright</u> Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1959</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Charles Wright</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Bellman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Thomas Wright</u> Address <u></u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child found dead in bed.</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>				20f. (City or town) (County) (State) <u></u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-14-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Allen Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. S. Baker</u> ADDRESS <u>300 W. 1st St.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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02/10/2011